# ULSTER COUNTY RESOURCE RECOVERY AGENCY

## RESOLUTION NO. 2673

**RE: Authorizing and Approving Agency HRA and FSA Health Insurance Related Plans**

**WHEREAS,** the Ulster County Resource Recovery Agency (the "**Agency**") is a public benefit corporation engaged in Solid Waste Management and Recycling in Ulster County, and

**WHEREAS**, the Agency is an employer that offers eligible employees health benefits, such as Health Reimbursement Arrangement ("**HRA**") and Flexible Spending Account ("**FSA**") Health Insurance Related Plans, and

**WHEREAS**, the Agency has received information concerning HRA and FSA Health Insurance Related Plans, and in compliance with the Employee Retirement Income Security Act of 1974, as amended from time to time ("**ERISA**"), the Agency amends and restates its HRA and FSA plans, and

**WHEREAS**, a Summary Plan Description is required for each HRA Plan and FSA Plan benefits and must be properly disclosed to UCRRA employees to comply with ERISA, and

**NOW, THEREFORE, BE IT**

**RESOLVED,** that the form of amended and restated UCRRA HRA Plan ("**HRA Plan**"), effective January 1, 2026, presented to this meeting is hereby approved and adopted by the Board, and that the proper agents of the Agency are hereby authorized and directed to execute and deliver to the Agency's appointed Administrator of said HRA Plan one or more counterparts of the HRA Plan, and be it further

**RESOLVED**, that the Administrator shall be instructed to take such actions that the Administrator deems necessary and proper in order to implement the HRA Plan, and to set up adequate accounting and administrative procedures for the provision of benefits under the HRA Plan, and be it further

**RESOLVED,** that the form of amended and restated UCRRA FSA Plan ("**FSA Plan**"), effective January 1, 2026, presented to this meeting is hereby approved and adopted by the Board, and that the proper agents of the Agency are hereby authorized and directed to execute and deliver the FSA Plan to the Agency's appointed Administrator, which can be executed in one or more counterparts, and be it further

**RESOLVED**, that the Administrator shall be instructed to take such actions that the Administrator deems necessary and proper in order to implement the FSA Plan, and to set up adequate accounting and administrative procedures for the provision of benefits under the FSA Plan, and be it further

**RESOLVED,** that the proper agents of the Agency shall act as soon as possible to notify the employees of the Agency of the adoption of the HRA and FSA Plans and to deliver to each employee: (1) a copy of the Summary Plan Description of the HRA Plan, and (2) a copy of the Summary Plan Description of the FSA Plan, true copies which are attached hereto respectively

as **Exhibit A** and **Exhibit B**, and are hereby approved and adopted by the Board at this meeting, and be it further

**RESOLVED**, that the Executive Director and staff are authorized to take all steps necessary to carry out this resolution, and be it

**RESOLVED**, that this resolution shall take effect immediately.

Moved by: _____ Seconded by: _____

Vote: Ayes:_____ Nays: _____ Absent: _____

Date: March 26, 2026

Financial Impact: N/A
See attachments.


# Ulster County Resource Recovery Agency

Ulster County Resource Recovery Agency
PO Box 6219
Kingston, NY 12402

## Ulster County Resource Recovery Agency HRA Plan

## Summary Plan Description

## Amended and Restated January 01, 2026

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02. How Claims Are Submitted

## INTRODUCTION

This is the Summary Plan Description (the "SPD") for the Ulster County Resource Recovery Agency HRA Plan, a Health Reimbursement Arrangement (the "HRA"). This SPD summarizes your rights and obligations as a participant (or beneficiary) in the HRA.

Read this SPD carefully so that you understand the provisions of our HRA and the benefits you will receive. You should direct any questions you have to the Plan Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this SPD and the plan document, the plan document will control.

## I. ELIGIBILITY

01. **What Are the Eligibility Requirements for this HRA?**

    You will be automatically enrolled in the HRA when you enroll in the Employer's group medical plan or are covered under another group health plan that does not exist solely of excepted benefits, unless you have opted out of the HRA.

02. **When is My Entry Date?**

    An Eligible Employee who has satisfied the conditions of eligibility pursuant to the Section titled "Eligibility" shall become a Participant effective on the date such Employee is enrolled in the Employer's group medical plan.

03. **Are There Any Employees Who Are Not Eligible?**

    Yes, employees who are not eligible to receive medical benefits under the group medical plan, or who are not enrolled in another group health plan that does not exist solely of excepted benefits, are not eligible to join the HRA.

## II. BENEFITS

01. **What Benefits Are Available?**

    The HRA allows for reimbursement for expenses as described in the Appendices of this document. The expenses that qualify are those permitted by Section 213(d) of the Internal Revenue Code.

    The amounts provided to the HRA by your employer will be made available on the first day of the plan year.

    Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. Any amounts reimbursed under the HRA may not be claimed as a deduction on your personal income tax return or reimbursed by other health plan coverage.

    If the maximum amount available for reimbursement for a Coverage Period is not utilized in its entirety, refer to Appendix A for information on how these funds will be handled.

02. **What is the "Plan Year"?**

    The "Plan Year" begins January 01 and ends December 31.

03. **What is the "Coverage Period"?**

    The period of the current "Coverage Period" in which the individual is an eligible employee on or after his or her plan entry date.

04. **How are payments made from the HRA?**

    The group Health Plan Carrier will submit requests for reimbursement of expenses you have incurred during the course of a Coverage Period for Qualified Medical Expenses as described in Appendix A. All claims need to be submitted for reimbursements no later than 180 days after the end of the Coverage Period (that is, no later than 06/29).

    In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) at the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

    You will be provided with a Debit Card to pay for eligible prescription expenses. This card can be used at pharmacies to pay for any medicine or drug that is prescribed by your doctor. If your pharmacy does not accept Debit Cards, you may submit a manual claim to the Plan Administrator with proof of the expenses you have incurred and that they have not been paid by any other health plan coverage.

    Remember, reimbursements made from the HRA are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

05. **What Happens If I Terminate Employment?**

    If your employment is terminated during the Plan Year for any reason, your participation in the HRA will cease on the date of your termination, and you will not be eligible to be reimbursed for any expenses incurred past that date. You must submit claims for any expenses incurred prior to your termination of employment within 180 days after you terminate employment. Any unused amounts will be forfeited.

06. **Uniformed Services Employment and Reemployment Rights Act (USERRA)**

    If you are going into or returning from military service, the Uniformed Services Employment and Reemployment Rights Act of 1994 may give you special rights to health care coverage under the HRA. These rights can include extended health care coverage. If you may be affected by this law, ask your Plan Administrator for further details.

07. **Newborn and Mothers Health Protection Act**

    Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the HRA or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

08. **Qualified Medical Child Support Order**

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

## III. GENERAL INFORMATION ABOUT OUR HRA

This Section contains certain general information, which you may need to know about the HRA.

01. **General HRA Information**

"Ulster County Resource Recovery Agency HRA Plan" is the name of the Plan.

Your Employer has assigned Plan Number 515 to your Plan.

This HRA is integrated with a group health plan entitled the "Ulster County Resource Recovery Agency Health Plan", which has been assigned policy number 417042.

The company amends and restates this Plan as of January 01, 2026 with an original effective date of January 01, 2015.

Your Plan's records are maintained on the basis of a period of time known as the "Plan Year." The Plan Year begins on January 01 and ends December 31 (the "Plan Year").

02. **Employer Information**

Your Employer's name, address, and identification number are:

Ulster County Resource Recovery Agency
PO Box 6219
Kingston, NY 12402
EIN: 14-1695478

03. **Plan Administrator Information**

The name and address of your Plan Administrator are:

MVP Health Care
PO Box 2207
Schenectady, NY 12301

The Plan Administrator will also answer any questions you may have about our HRA. The Plan Administrator has the exclusive right to interpret the appropriate HRA provisions. Decisions of the Plan Administrator are conclusive and binding. You may contact the Plan Administrator for any further information about the HRA.

04. **Agent for Service of Legal Process**

Should it ever be necessary, you or your personal representative may serve legal process on the agent for service of legal process for the HRA. The HRA Agent of Service is:

Ulster County Resource Recovery Agency
PO Box 6219
Kingston, NY 12402

Legal process may also be served on the Plan Administrator.

05. **Type of Administration**

The HRA is a health reimbursement arrangement. The HRA is not funded or insured. Benefits are paid from the general assets of the Employer.

06. **Claims Administrator Information**

The name and address of your Claims Administrator are:

MVP Health Care
PO Box 2207
Schenectady, NY 12301

The Claims Administrator keeps the claims records for the HRA and is responsible for the claims administration of the HRA. The Claims Administrator will also answer any claims-related questions you may have about the HRA.

## IV. ADDITIONAL HRA INFORMATION

01. **Your Rights Under ERISA**

HRA Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

a. Examine, without charge, at the Plan Administrator's office, all HRA documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the HRA with the U.S. Department of Labor (also, available at the Public Disclosure Room of the Employee Benefits Security Administration).

b. Obtain copies of all HRA documents and other HRA information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for the copies.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time frames.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court; provided, such suit may be filed only after the plan's review procedures described herein have been exhausted and only if filed within 90 days after the final decision on review is provided, or, if a later date is specified in a booklet, certificate or other documentation for a particular Welfare Program, only if filed by such later date.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the HRA and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Plan Administrator to provide the materials and pay you up to $112 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if a HRA Participant disagrees with the HRA's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for HRA Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the HRA. The individuals who operate the HRA, called "fiduciaries" of the HRA, have a duty to do so prudently and in the interests of the HRA Participants and their beneficiaries. No one, including the Employer or any other person, may fire a HRA Participant or otherwise discriminate against a HRA Participant in any way to prevent the HRA Participant from obtaining benefits under the HRA or from exercising his or her rights under ERISA.

If it should happen that HRA fiduciaries misuse the HRA's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the HRA, you should contact the Plan Administrator. If you have any questions about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

02. **How claims are submitted**

When you have a Claim to submit for eligible prescriptions, you must:

1. File the claim in accordance with the instructions of the Plan Administrator.

2. Submit copies of all supporting receipts and/or Explanation of Benefits (EOB) from your insurance carrier for which you are requesting reimbursement.

Your group Health Plan Carrier will submit all claims to the Claims Processor for processing. All claims with be processed in accordance with the HRA plan design contained in Appendix A of this

document.

A Claim is defined as any request for a HRA benefit, made by a claimant or by a representative of a claimant that complies with the HRA's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Unless otherwise specified, decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

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| Notification of whether claim is accepted or denied | 30 days |
| Extension due to matters beyond the control of the Plan | 15 days |

Insufficient information on the claim:

| | |
|---|---|
| Notification of | 15 days |
| Response by Participant | 45 days |
| Review of claim denial | 60 days |

The Claims Administrator will provide written or electronic notification of any Claim denial. The notice will state:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
2. The specific reason or reasons for the adverse determination.
3. Reference to the specific HRA or Welfare Program provisions on which the determination is based.
4. A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.
5. A description of the HRA's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the claimant's right to bring a civil action under Section 502 of ERISA following a final appeal.
6. Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.
7. In the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.
8. The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision to the Claims Administrator. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the HRA. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the Claim determination;
2. was submitted, considered, or generated in the course of making the Claim determination, without regard to whether it was relied upon in making the Claim determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim determinations are made in accordance with HRA documents and HRA provisions have been applied consistently with respect to all claimants;
4. or constituted a statement of policy or guidance with respect to the HRA concerning the denied Claim.

The review will take into account all comments, documents, records, and other information

submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the HRA who is neither the individual who made the adverse determination nor a subordinate of that individual.

After receiving notice of an adverse benefit determination or a final internal adverse benefit determination, a claimant may file with the HRA a request for an external review. A claimant may request from the Plan Administrator additional information describing the HRA's external review procedure.

IF YOU HAVE QUESTIONS

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including the Patient Protection and Affordable Care Act and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

# Appendix A - HRA Plan Benefit

**Employee Class**
- Individual

**Qualified benefits**
- Deductible - Medical
- Rx drugs - Health (prescriptions)

**Plan Coverage**
- Medical

**Reimbursement Schedule**
- The HRA will pay $7,200.00 of qualifying expenses up to a max benefit limit of $7,200.00.

**Unused HRA Funds**
- Unused benefits at the end of the coverage period shall be forfeited.

# Appendix A - HRA Plan Benefit

**Employee Class**
- Family

**Qualified benefits**
- Deductible - Medical
- Rx drugs - Health (prescriptions)

**Plan Coverage**
- Medical

**Reimbursement Schedule**
- The HRA will pay $14,400.00 of qualifying expenses up to a max benefit limit of $14,400.00.

**Unused HRA Funds**
- Unused benefits at the end of the coverage period shall be forfeited.


# Ulster County Resource Recovery Agency

Ulster County Resource Recovery Agency
PO Box 6219
Kingston, NY 12402

## Ulster County Resource Recovery Agency FSA Plan

## Summary Plan Description

## Amended and Restated January 01, 2026

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# Ulster County Resource Recovery Agency

# Ulster County Resource Recovery Agency FSA Plan

## INTRODUCTION

The Company's Flexible Benefit Plan ("Plan") has been established to allow Eligible Employees to pay for certain benefits on a pre-tax basis. There are specific benefits that you may elect, and they are outlined in this Summary Plan Description. You will also be informed about other important information concerning the Plan, such as the conditions you must satisfy before you can join and the laws that protect your rights.

Read this Summary Plan Description ("SPD") carefully so that you understand the provisions of the Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the Plan document, which governs the operation of the Plan. The Plan document is written in much more technical language. Please note that if the non-technical language in this SPD and the legal language of the Plan document conflict, the Plan document will always govern the Plan. Also, if there is a conflict between any of the insurance contracts and either the Plan document or this Summary Plan Description, the insurance contracts will control the respective insurance policies. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator.

The Plan is subject to the Internal Revenue Code and other federal and state laws and regulations that may affect your rights under this plan. This SPD explains the current details of the Plan in order to comply with all applicable legal requirements. From time to time, the Plan may be revised due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. This Plan may be amended or terminated by the Company. If the Plan is ever amended or changed, the Company will notify you.

This SPD was designed to provide you with information regarding the Company Flexible Benefit Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other assigned person). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About our Plan."

## I. ARTICLE - ELIGIBILITY

01. **How can I participate in the Plan?**

    Before you can become a Participant in the Plan, there are certain conditions that you must satisfy. First, you must be an active employee working 30.00 or more hours per week or 130 hours per month and meet the eligibility requirements.

    After that, you must enroll in the Plan on the "entry date" that has been established for all employees. The "entry date" is defined in Question 3 below. However, in certain limited situations, you may enroll in the Plan at other times as well. See the Article titled: "Contributions".

02. **What are the eligibility requirements for our Plan?**

    You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan or, the date you provide certification of enrollment in another group health plan, and satisfy the other eligibility requirements established by your employer as defined in section 1.

03. **When can I enter the plan?**

    You can enter the Plan on the day you met the eligibility requirements.

04. **How do I enroll in the Plan?**

    Before you can join the Plan, you must complete an enrollment form. The enrollment form will allow you to select which benefits you want to participate in under the Plan. This form will also authorize the Company to redirect some of your earnings in order to pay for the benefits you select.

    However, if you are already covered under any of the insured benefits, you will automatically participate in this Plan to the extent of your premiums unless you elect not to participate in this Plan. These benefits are listed in the Article titled: "Benefits".

## II. ARTICLE - OPERATION

01. **How does this Plan operate?**

Before the start of each Plan Year, you will be able to elect to have some of your earnings contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your earnings that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under this Plan, you cannot claim a Federal income tax credit or deduction on your return. Participation in this plan is completely voluntary.

## III. ARTICLE - CONTRIBUTIONS; ELECTIONS

01. **How much of my pay may the Employer redirect?**

Each year, we will automatically contribute on your behalf enough of your compensation to pay for the insurance coverage provided unless you elect not to receive any or all of such coverage. You may also elect to have us contribute on your behalf enough of your compensation to pay for any other benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year on a per payroll basis.

02. **What happens to contributions made to the Plan?**

Prior to the Plan start date each year, you must decide on the amount of pre-tax dollars you want to contribute to the Plan. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, those dollars will be used to pay those expenses as they arise during the Plan Year. In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) at the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer, including those unused funds remaining in your Health Flexible Spending Account after the grace period and any run-out period described in the Article titled: "Benefits".

For information regarding the administration of contributions in specific accounts under this Plan, please refer to the Article titled: "Benefits".

03. **When must I decide which accounts I want to use?**

You are required by Federal regulations to decide during the enrollment or election period (defined below) prior to the Plan Year start. You must decide which accounts you want and how much you want to contribute to each account.

If you are already covered by any of the insured benefits offered by this Plan, you will automatically become a Participant to the extent of the premiums for such insurance, unless you elect during the election period (defined below) not to participate in the Plan.

04. **When is the election period for our Plan?**

You will make your initial election on or before your entry date. (Please review the Article titled: "Eligibility" to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Company and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Company will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

05. **May I change my elections during the Plan Year?**

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections.

You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in

status. In addition, there are laws that give you certain other rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if the Company adds a new coverage option or eliminates an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse, former spouse or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

06. **May I make new elections in future Plan Years?**

Yes. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, the Company will assume you want your elections for insured benefits only to remain the same and you will not be considered a Participant for the non-insured benefit options under the Plan for the upcoming Plan Year.

## IV. ARTICLE - BENEFITS

01. **What benefits are offered under the Plan?**

    You may choose to receive your entire compensation or use a portion to pay for benefits under this plan.

02. **Health Flexible Spending Account**

    The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code and that are not covered by our insured medical plan, and to save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for out-of-pocket medical, dental and/or vision expenses incurred by you and your dependents.

    Drug costs, including insulin, may be reimbursed. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

    The most that you can contribute to your Health Flexible Spending Account for the Plan Year is $3,400.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code. In addition, you may carry over any amount left in your account up to $680.00. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. This amount can be used the following Plan year to pay for eligible expenses.

    In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. The Company will also provide you with a debit card to use to pay for qualified Medical Expenses. The Administrator will provide you with further details about the debit card. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. As required by law, reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

    You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A “child” is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status for purposes of coverage changes.

03. **Dependent Care Flexible Spending Account**

    The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

    The most that you can contribute to your Dependent Care Flexible Spending Account for the Plan Year is $7,500.00.

    An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

    a. A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

    b. An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

    c. An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

    You should make sure that the Dependent Care Expenses you are currently paying qualify under our Plan.

    The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) $7,500.00 (if you are married filing a joint return or you are head of a household) or $3,750.00 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed annual earned income (a spouse who is a full time student or incapable of caring for himself/herself has a deemed monthly earned income of $250 for one dependent or

$500 for two or more dependents).

Also, in order to be able to exclude from your income the reimbursements made to you from this account, you must provide on your tax form for the year the name, address, and in most cases, the taxpayer identification number of the service provider, as well as the amount of such expense. In addition, Federal tax laws permit a tax credit for certain Dependent Care Expenses you may be paying even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Consult with your tax adviser for further information.

04. **Premium Expense Account**

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various group insurance programs the Company offers you. These premium expenses include:

Under this Plan, the Company will allocate the pre-tax premium withholding to the accounts established under the Plan pursuant to the Participants' elections. Certain limits on the amount of coverage that can be paid through pre-tax premiums may apply.

The Company may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. The Company will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

## V. ARTICLE - BENEFIT PAYMENTS

01. **When will I receive payments from my accounts?**

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will be reimbursed from the Health Flexible Spending Account up to your total annual election. You will be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

02. **What happens if I don't spend all Plan contributions during the Plan Year?**

If you have unused contributions in your account at the end of the current Plan Year, those monies will be forfeited to the Employer. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited.

At the end of the Plan Year, and after all eligible reimbursements have been made, any unused funds up to $680.00 in your Health Flexible Spending Account will roll over into the new Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. Any unused funds left in the account in excess of maximum limit will be forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year.

For the Dependent Care Flexible Spending Account, you can continue to receive reimbursement for expenses incurred during the first 2.5 months immediately following the end of the Plan year, until such unused funds are depleted. You must submit claims no later than 90 days after the end of the 2.5 month Grace Period.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

03. **What happens if my employment terminates?**

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

a. You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

b. You will still be able to request reimbursement for qualifying Dependent Care Expenses up to 90 days after the date of termination from the balance remaining in your Dependent Care Account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after termination.

c. Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit, within 90 days after the date of termination, claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made.

04. **Will my Social Security benefits be affected?**

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as the Company contributions to Social Security on your behalf.

## VI. ARTICLE - HIGHLY COMPENSATED AND KEY EMPLOYEES

01. **Do limitations apply to highly compensated employees?**

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or are highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

## VII. ARTICLE - PLAN ACCOUNTING

01. **Periodic Statements**

Periodically during the Plan Year, the Administrator will provide you with a statement of your account that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

## VIII. ARTICLE - GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

01. **General Plan Information**

Ulster County Resource Recovery Agency FSA Plan is the name of the Plan.

Your Employer has assigned Plan Number 515 to your Plan.

The company amends and restates this Plan as of January 01, 2026 with an original effective date of January 01, 2015.

Your Plan's records are maintained on a twelve-month period of time known as the Plan Year. The Plan Year begins on January 01 and ends on December 31.

02. **Employer Information**

Your Employer's name, address, and tax identification number are:

Ulster County Resource Recovery Agency

PO Box 6219
Kingston, NY 12402

FEIN: 14-1695478

03. **Plan Administrator Information**

The name and address of your Plan's Administrator are:

MVP Health Care
PO Box 2207
Schenectady, NY 12301

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

04. **Agent for Service of Legal Process**

Should it ever be necessary, you or your personal representative may serve legal process on the agent for service of legal process for the Plan. The Plan's Agent of Service is:

Ulster County Resource Recovery Agency
PO Box 6219
Kingston, NY 12402

05. **Type of Administration**

The type of Administration is Employer Administration.

06. **Claims Submission**

Claims for expenses should be submitted to:

MVP Health Care
PO Box 2207
Schenectady, NY 12301

**KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.